Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

" Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

" Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

" Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Robert M. Day

(Signature of Agency Head)

SCHIP Program Name (s) HealthWave 21

SCHIP Program Type _____Medicaid SCHIP Expansion Only
__X__ Separate SCHIP Program Only
_____Combination of the above

Reporting Period **Federal Fiscal Year 2001 (10/1/2000-9/30/2001)**

Contact Person/Title Bobbie Graff-Hendrixson, Senior Manager, Health Care Delivery Systems

Address Docking State Office Building, 915 SW Harrison, Room 651 South

Topeka, KS 66612

Phone (785) 296-7010 Fax (785) 296-4813

Email BLGH@SRSKANSAS.ORG

Submission Date January 2, 2002

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter NC for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility NC

B. Enrollment process NC

C. Presumptive eligibility NC

D. Continuous eligibility NC

E. Outreach/marketing campaigns

The outreach component of the MAXIMUS, Inc. (MAXIMUS, the contractor managing the centralized Clearinghouse for applications processing and marketing) contract was removed in the beginning of the State Fiscal Year 2002 (July 1, 2001), and additional funding was allocated to each of the agency s Area Offices as of October 1, 2001 to provide a more targeted outreach for their specific populations. In the interim, the separate Robert Wood Johnson Covering Kids grant program was in operation providing outreach functions throughout the state.

The marketing component will remain with MAXIMUS. In addition, the new state fiscal year saw the merging of the application and brochure into one packet, complete with an envelope and income guideline chart. This document was patterned off the Iowa model. All billboards, commercials, PSAs, etc. now carry the same pictures and colors to promote the theme. The next revision of the application/brochure is being finalized and this application version will then be translated in the top 10 languages for the LEP requirements. This will occur during FFY 2002.

The Covering Kids grant, a partnership with the Kansas Children's Service League, will close in January of 2002. An additional grant request has been submitted but the outcome is not expected until late December 2001 or early January 2002. This grant would provide funding for two local coalitions and one statewide coalition.

F. Eligibility determination process NC

G. Eligibility redetermination process NC

H. Benefit structure NC

I. Cost-sharing policies NC

J. Crowd-out policies

Effective July 1, 2001, persons terminating other insurance coverage within the prior six months of application were no longer ineligible for coverage under HealthWave 21. The Clearinghouse, managed by MAXIMUS, is tracking these applications to monitor potential crowd-out issues.

K. Delivery system

The physical health contractor for HealthWave 21 and capitated Title 19 managed care, now known as HealthWave 19, is the same as of July 1, 2001. Having the same physical health contractor for both programs will enhance continuity of care as families change funding streams. Distinct mental health and dental services contractors are serving as coordinators of care for the Title 19 managed care population and are continuing the state-statutorily-required capitated care for the Title 21 population.

L. Coordination with other programs (especially private insurance and Medicaid)

The use of common delivery systems and coordination of networks has improved the functioning of the SCHIP program relative to the Medicaid program.

M. Screen and enroll process NC

N. Application

As of July 1, 2001, the application and brochure were merged into one packet, complete with envelope and income guidelines chart. This document was patterned off the Iowa model. All billboards, commercials, PSAs, etc. now carry the same pictures and colors to promote the theme. The next revision of the application and brochure is being finalized and this application version will then be translated in the top 10 languages for the LEP requirements.

O. Other NC

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered, low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

From 1997 to today, certain studies and reports have been promulgated regarding the uninsured in Kansas. In summary, those are:

September 1997 - The Kansas Health Foundation and the Kansas Department of Health and Environment funded a statewide survey and review of secondary data on insurance coverage. That survey found that 9.4% of the nonelderly population in Kansas was uninsured, and that 31% of the uninsured were children under age 18 (approximately 64,200 children, based on the 1994 Census figures) who were without insurance at the time of the survey. Another 29.9% of those uninsured at some point during the prior year (approximately 25,700) were in this age group. This results in a range of uninsurance for this age group of 64,200 at a point in time to 89,900 at any time over the past year. Adding children aged 18 to this review would, by interpolation, increase the range of uninsured to 67,800 to 91,500.

CPS data from 1993, 1994, 1995 - This data is the basis for the SCHIP allocations in FFY 1998. While not statistically significant for Kansas, it showed that there were 60,000 uninsured children under age 19, plus or minus 12,300, for a range of 47,700 to 72,300 children.

March 2001 - Kansas Health Institute Issue Brief 11 - As part of the three-year evaluation of HealthWave 21, the dynamics of the Title 21 and Title 19 programs between July 1, 1998 and June 30, 2000 were evaluated. One of the findings was a majority (68%) of children entering HealthWave 21 had prior experience with Medicaid, and only 19% to 30% of enrollees were new to public insurance. This implies that while children aging out of the stair-step Medicaid eligibility ladder still have access to no-cost or low-cost insurance, the program is not reaching as many of the previously uninsured as was anticipated.

August 2001 - Kansas Health Insurance Study - This study, commissioned by the Kansas Insurance Department and funded by a grant from the Health Resources and Services Administration, Department of Health and Human Services, looked at insurance status by age, gender, marital status, education, employment status, and region. Questions about the reasons for uninsurance and health status were asked. This study found that 7.8% of children under age 19 were not insured at the time of the survey. While this percentage is lower than that found in the August 1997 survey for children under age 18 (9.4% versus 7.8%), it translates into approximately 55,600 children, based on the 2000 population figures for Kansas from the Census Bureau.

Other notable findings were that children were enrolled in Medicaid/HealthWave 21 at three times the rate of the general public, and that the main reason for uninsurance was the cost.

These studies in the aggregate imply that between 1997 and 2001, the reduction in the number of uninsured children under age 19 is somewhere between 12,200 and 35,900, with some enrolled in Medicaid and some enrolled in HealthWave 21.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

As of September 2001, Kansas had 37,146 children enrolled in Medicaid as a direct result of SCHIP outreach. This figure is derived by the state s contractor, MAXIMUS, who operates the centralized Clearinghouse applications processing and enrollment function, and tracks submission of the simplified, joint, mail-in applications. Files from the state s automated eligibility system are matched with Clearinghouse records of applications returned to, and tracked by, the Clearinghouse. This match finds the number of children eligible in that month for Medicaid whose eligibility was determined from submission of a simplified application. As of December 1, 2001, the number of children enrolled in Medicaid as a result of SCHIP outreach had risen to 51,939.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

We have no other evidence at the current time.

As part of the outside evaluation being conducted by the Kansas Health Institute, in cooperation with the Department of Social and Rehabilitation Services (SRS) and other entities, additional information regarding this issue will be determined. One of the projects in the evaluation is to examine the impact of HealthWave on reducing the number of low-income uninsured children, explain the existence of low-income children who continue to be uninsured, and identify differences in health care access and health status between insured and uninsured low-income children.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What is the data source(s) and methodology used to make this estimate?

NA

What was the justification for adopting a different methodology?

NA

What is the State s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

NA

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

NA

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State s strategic objectives, performance goals, performance measures and progress toward meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State s strategic objectives for your SCHIP program, as specified in your State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress toward meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter NC (for no change) in column 3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Reduce the number of uninsured non-Medicaid eligible children less than 19 years of age and below 200% FPL in the State of Kansas	By December 31, 2001, at least 50,000 previously uninsured non-Medicaid eligible children will be enrolled in the SCHIP program.	Data Sources: Administrative data and Current Population Survey (CPS) data Methodology: Count number of children enrolled in HealthWave as of dates. Progress Summary: As of September 1, 2001 there were 23,042 children enrolled in HealthWave. The original estimate given in the state plan did not account for the number of Medicaid eligible, but not enrolled, children discovered as a result of the SCHIP/Medicaid joint application process. As of the same time period 37,146 additional children were determined to be Medicaid eligible, as a result of SCHIP outreach, for a total of 60,188. Additional information is given in the response to question 1.2 above.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Assure that the enrolled children with significant health needs have access to appropriate care.	Reduce the number of cases of hospitalization due to asthma among the enrolled children.	Data Sources: Administrative data for hospital stays and services. Methodology: Encounter data with asthma CPT codes for SFY 2000 was used. Beneficiaries with the diagnosis of asthma at least one time during the state fiscal year were determined. Of these beneficiaries, the number hospitalized with the diagnosis of asthma was found. Progress Summary: SFY 2000, there were 974 children enrolled whose primary diagnosis was asthma, and 168 of them (17.24%) were hospitalized. When FFY 2000 data is available, it will be used for comparison purposes.

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Assure that the enrolled children receive high quality health care services.	By December 31, 2000, at least 90% of SCHIP enrollees will report overall satisfaction with their health care.	Data Sources: Consumer Assessment of Health Plans Study (CAHPS) survey results. Methodology: Standard CAHPS methodology. Numerator: MCO 1 = 454 MCO 2 = 563 Denominator: MCO 1 =1,050 MCO 2 = 1,050 Progress Summary: CAHPS survey information is available for the 2001 reporting period (2000 data). MCO 1 / MCO 2 Getting needed care 87.1% / 81.4% Getting care quickly 86.7% / 86.4% How well Drs communicate 92.2% / 90.8% Courteous & helpful office staff 93.0% / 89.8% Customer service 73.8% / 71.1% Rating of personal Dr. 75.1% / 72.2% Rating of specialist 72.0% / 74.5% Rating of health care received 77.8% / 79.1% Rating of health plan 78.0% / 80.4% The overall ratings of MCO1 and MCO2 have significantly improved since the 1999 data reported in the prior annual report.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Increase the percentage of enrolled children with regular preventive care.	By December 31, 1999, at least 75% of enrolled children through 2 years of age will receive one or more age-appropriate immunizations.	Data Sources: Health Plan Encounter Data and Information Set (HEDIS) data. Methodology: Hybrid and Administrative methodology Progress Summary: MCO 1 did not have a large enough denominator for HEDIS. MCO 1 reported zero as their HEDIS measure. For MCO 2, the following results were reported:

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	By December 31, 1999, at least 80% of enrolled children will receive one or more Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service.	Immunizations: Combo 1 36.30% Combo 2 27.41% DTP/DTaP 47.41% Hepatitis B 47.41% HiB 52.59% MMR 74.07% IPV/OPV 50.37% VZV 52.59% Data Sources: HEDIS 2000 Indicator Summary for MCO2. Methodology: Administrative and Hybrid Numerator: Varies by indicator Denominator: Total exams needed per periodicity schedule Progress Summary: Using the Hybrid method the total exams needed per periodicity schedule were determined by the number of visits in various age groups. Well child visits during the first 15 months of life: 0 visits 0% (due to 0 numerator events) 1 visits 8.70% 2 visits 13.04% 3 visits 17.39% 4 visits 8.70% 5 visits 17.39% 6 visits 34.78% There was a total of 23 children who met the criteria for this measure. Well child visits during the 3rd, 4th, 5th and 6th year of life: 59.06% There was a total of 855 children who met this criterion. Well child visits for adolescents: 39.08% There was a total of 2,495 children who met this criterion.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OTHER OBJECTIVES		
		Data Sources: Methodology: Progress Summary:

Objective #1: Reduce the number of uninsured non-Medicaid eligible children less than 19 years of age and below 200% FPL in the State of Kansas

As of December 1, 2001, there were 24,138 children in enrolled HealthWave 21 and an additional 51,939 children enrolled in Medicaid as a result of the HealthWave application process for a total of 76,077 children with health insurance coverage accessed through the simplified mail-in application process. See the response for question 1.2 for additional information on estimated reductions in the number of uninsured children.

An outside, three-year evaluation being conducted by the Kansas Health Institute should give us some additional information in this area. One of the projects within the evaluation is to examine the impact of HealthWave on reducing the number of low-income uninsured children in Kansas, explain any continuing presence of uninsured low-income children, and identify differences in health care access and health status between insured and uninsured low-income children.

Objective #3: Assure that the enrolled children with significant health needs have access to appropriate care.

An outside evaluation is underway conducted by the Kansas Health Institute which should give us additional information regarding the experience of all children enrolled in HealthWave with regard to access to and appropriateness of care.

Objective #5: Increase the percentage of enrolled children with regular preventive care.

EPSDTEPSDT screens were 45.6% for one of the HealthWave physicalEPSDT screens were 45.6% for one of the (MCO(MCO 2). The State believes there are outstanding claims and reporting issues which need to be resolvedresolved before these percentages will be truly reflective of what is occurring in the Healtresolved befo program.

1.4 IIfIf any performance goals have not been met, indicate the barriers or constraIf any performan meeting them.

See notes to the above table.

1.5 DiscussDiscuss your State sDiscuss your State s progress in addressing any specificDiscuss your St to assess in your State plan that are not included as strategic objectives.

TheThe remaining objective not discussThe remaining objective not discussed in the The remainin employer-basedemployer-based health insurance for employees with SCHIP-eligible children. Thisemploye hashas become an non-issue in Kansas, andhas become an non-issue in Kansas, and the one priorhas beco monthmonth waiting period for persons with prior month waiting period for persons with prior insura objective will be removed as part of a future state plan amendment.

1.6 DiscussDiscuss future performance measurement activities, including a projection of when additional data are likely to be available.

AsAs has been mentionedAs has been mentioned earlier, a three-year evaluation of HealthWave beingAs has KansasKansas HealKansas Health IKansas Health Institute is currently underway in cooperation with SR ThisThis evaThis evaluatioThis evaluation is being funded through various grants including the Packard U.S.U.S. Health Resources and Services AU.S. Health Resources and Services AdminU.S. Health R MethodistMethodist Health Ministry Fund, and the Agency for Health Care Policy and Research (now thethe Agency for Healthcare Research andthe Agency for Healthcare Research and Quality). Other entiti are:are: the Kansas Department of Health andare: the Kansas Department of Health and Environment;are: t SocialSocial Welfare aSocial Welfare and Nursing; the University of Kansas Medical Center; Kans University;University; and the Kansas Foundation for Medical Care. Various parts of this study have beenbeen discussed throughout this evaluation in response to various specbeen discussed throughout general this evaluation is designed to:

ExamExamiExamineExamine the impact of HealthWave on reducing the number of low-in uninsureduninsured chuninsured children uninsured children in Kansas, explain any contin low-incomelow-income children,low-income children, and identify differenceslow-income c status between insured and uninsured low-income children;

DetermineDetermine the impact of HealthWave on healthDetermine the impact of Healt
utilizationutilization for low-income children in the program, and autilization for low-in
group of Medicaid enrollees;
EvEvaluateEvaluate how well the HealthWave program provides health servEvaluate h
particularlyparticularly vulnerable childrenparticularly vulnerable children including urbanpa
immigrants,immigrants, children in poor, rural areas and children with menimmigrants,
needs; and
AssesAssessAssess the effect of HealthWave on the health care market, particularly thAss
traditionaltraditional safety net providers that exist in rural and other disadvantaged
areas of the state.

DataData for the evaluation will beData for the evaluation will be gathered through surveys, focus groups,Da
datadata anddata and other secondary data suchdata and other secondary data such as vital statistics, hospit
HealHealthHealth IHealth Insurance Information System. Some data is available now, and is atta
Additional data will be disseminated through the end of calendar year 2002.

SeeSee also the responses to question 2.8 regarding See also the responses to question 2.8 regardi
completed by the state s contract External Quality Review Organization.

**1.7 PleasePlease attach any studies, analyses or other documents addrPlease attach any stu
enrollment,enrollment, access, quality, utilization, costs, satisfaction, or other aspectsenrollment
SCHIP program s performance. Please list attachments here.**

Attachments:

Kansas Health Institute, Issue Brief No. 10
Kansas Health Institute, Issue Brief No. 11
Kansas Health Institute, Forum Summary
Kansas Health Survey, August 2001
Denial Summary

SECTION 2. AREAS OF SPECIAL INTEREST

ThisThis section has been designed to allow you toThis section has been designed to allow you to address topic including; states, federal officials, and child advocates.

2.1 Family coverage:

A. IfIf your State offersIf your State offers family coverage, please provideIf your State offers family coverag particparticipationparticipation in this program and how this program is coordinated with other program IIncludeInclude in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

Not applicable. Family coverage is not offered in Kansas.

B. How many children and adults were ever enrolled inHow many children and adults were ever enrolled in y during FFY 2001 (10/1/00 - 9/30/01)?

Number of adults_____
Number of children_____

Not applicable. Family coverage is not offered in Kansas.

C. How do you monitor cost-effectiveness of family coverage?

Not applicable. Family coverage is not offered in Kansas.

2.2 Employer-sponsored insurance buy-in:

A. If your StateIf your State has a buy-in program, please provide a brief narrative about requirements for participationparticipation in thparticipation in this pparticipation in this program and how this prog program(s).

NotNot applicable. Kansas does notNot applicable. Kansas does not currently participateNot applicable. using SCHIP or Medicaid funding.

B. HowHow many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

Number of adults_____
Number of children_____

NotNot applicable.Not applicable. KansasNot applicable. Kansas does not currently participate in an empl using SCHIP or Medicaid funding.

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

CrowdCrowd outCrowd out is defined as dropping employer-sponsored or private-payinsuranceCrowd out i
during the 6-month period prior to receiving HealthWave coverage.

B. How do you monitor and measure whether crowd-out is occurring?

WeWe have no definitive data on theWe have no definitive data on the extent of crowd-out.We have no defin
onon how many applications won how many applications were denion how many applications were de
informationinformation may not giveinformation may not give an accurateinformation may not give an acc
potentialpotential applicants werepotential applicants were given, up until July1, 2001 whenpotential appli
regardingregarding the requirement of children being uninsuredregarding the requirement of children being
forfor this report.for this report. for this report. Families who already had children covered by other insura
submittedsubmitted an application becausesubmitted an application because they believedsubmitted an appli
nono wayno way at this timeno way at this time to discover the number of children whose parents dropped oth
andand let their child remain uninsured for six months before applying.and let their child remain uninsured
atat least six months beforeat least six months before at least six months before application, no info
coveragecoverage and why it was discontinued. The limited denial data we havecoverage and why it was dis
familiesfamilies with children already covered by health insuranfamilies with children already covered b
applications,applications, although the application form is jointly used forapplications, although the applica
and Title 19 beneficiaries can have other insurance coverage.

WeWe havWe have systems We have systems data for our Medical Program (MP) that gives us so
regardingregarding the number of applications denied because ofregarding the number of applications denied
bothboth SCHIP eligible and poverty-both SCHIP eligible and poverty-leboth SCHIP eligible and p
existingexisting healthexisting health insurance would only apply to SCHIP eligibility determinations. Aexi
ofof thisof this data is that the denialof this data is that the denial reason is an eligibility worker input field th
Finally,Finally, the automated eligibility system only allows one reason code toFinally, the automated eligibi
couldcould be more than one reason forcould be more than one reason for denialcould be more than one rea
totto theto the worker to choose which denial code to enter,to the worker to choose which denial code to en
the data.

C. WhatWhat has been the result of your analyses? Please summarize and attachWhat has been the result of you
or other documentation.

ForFor theFor the time period covered byFor the time period covered by this annual report (FFY 2001), st
existingexisting health insurance averaged 6.5% of all denials. When narrowed downexisting health insuranc
processed in the Clearinghouse, which eliminates allprocessed in the Clearinghouse, which eliminates all bu
averageaverage denial rate due to health insurances rose to 8.5% ofaverage denial rate due to health insur
samesame period, the average number ofsame period, the average number of total monthly denialssame pe
withwith an average of 337 totalwith an average of 337 total monthly denials at the Clearinghouse. Acco

thethe the presence othe presence of preexisting health insurance coverage accounts for a small to m
percentage of denials, although it has increased from the percentage reported last year.

TheThe SAS report that summarizes this data from thThe SAS report that summarizes this data fr
availableavailable for attachment. A spreadsheet summary of thisavailable for attachment. A spreadsheet su
only applicable to HealthWave 21 is attached.

D. Which anti-crowd-out policiesWhich anti-crowd-out policies have been most effective in discouraging the
publicpublic coverage forpublic coverage for private coverage in your SCHIPpublic coverage for private co
method used to derive this information.

WeWe have not seen evidence of crowd out sinceWe have not seen evidence of crowd out since the incepti
the previous policy requiringthe previous policy requiring a six-month waiting periodthe previous policy re
eliminated.

2.4 Outreach:

A. What activities have you foundWhat activities have you found most effective in reaching low-income,Wha
How have you measured effectiveness?

OneOne of the most effective ways to doOne of the most effective ways to do outreach is to beOne of the
thinkthink about health insurancethink about health insurance for their children. think about health insurance
KindergartenKindergarten Round-ups, school enrollments, HealthWave flyers sent home in early January
(during(during flu season) are very good times to connect(during flu season) are very good times to connect
healthhealth care needs. Outreachhealth care needs. Outreach works through schoolhealth care needs. Ou
throughroughroughoutthroughout the year when a child may need glasses, hearing tests or some other
treatment.

ScheduledScheduled timeScheduled times for famiScheduled times for families to complete an applic
applicationapplication assistance events sometimes take place in health departments during WICapplication
daysdays or schools during special events. This year the marketing department of Mdays or schools dur
beganbegan notifying the lobegan notifying the local media began notifying the local media whenever p
inclusioninclusion in theirinclusion in their community calendars. This resulted in an increased number of fa
completed an application or picked one up.

TheThe business community is another very effective partner in helThe business community is anot
encouragingencouraging them to enroll their children. Many employersencouraging them to enroll their chi
ofof business to presentations and applicationof business to presentations and application assistance. Emplo
ofof absent workers due toof absent workers due to children s illness. They also understandof absent worker
sensesense to offer their employees a benefit that will have such a significantsense to offer their employees a
WithinWithin the business community, small employers, the nursing homeWithin the business community, sm
andand temporary agencies all have lower-paid employees. Eachand temporary agencies all have lower-paid
workers time to talk to an outreach representative and in encouraging them to enroll.

EffectivenessEffectiveness is measured by the Effectiveness is measured by the numbeEffectiveness is number who take one. Application numbers are checked daily to monitor the effectiveness of particular types of activities. Enrollment numbers are reviewed monthly to help indicate wwhichwhich areas may need additional activities. Finally, quality reviews are done on evewhich ar outreachoutreach coordinator each week with a phone survey to oneoutreach coordinator each week wi with the prior week. Outreach coordinators are alsowith the prior week. Outreach coordinators are also g once a month.

B. HaveHave any of theHave any of the outreach activities been more successful inHave any of the outreach acti minorities,minorities, immigrants, and children living in rural areas)? How have yminorities, immig effectiveness?

ItIt has beenIt has been foundIt has been found that the most effective method ofreaching these segments of t isis to become involved in their communities. For instance, it s impois to become involved in th represrepresentrepresentativerepresentative who looks like or speaks the same language as a minority outreachoutreach representative who only speaks English could not have been successful inoutreach repres alongalong the side of the road in western Kansas and goingalong the side ofthe road in western Kansas and andand fill outand fill out applications during their breaks.and fill out applications during their breaks. A rep notnot have been well-received going into a café filled with Spanish speakers and asking immigrantsimmigrants if theirimmigrants if their children had health insurance and helpingimmigrants if the from on the spot.

ItIt is important to the African American community to have rIt is important to the African American AfricanAfrican American join themAfrican American join them in the parades, go to their faith communitie congregationscongregations or be available after the services for assistancecongregations or be available a

WhenWhen When there isn t an outreach coordinator who is a part of the population being targeWhen effortsefforts are focused on theefforts are focused on the social services agencies who help minorities or in otherother services. These agencies already have aother services. These agencies already have a well-estabi ofof the community they serve. If a person already helping with other social needs recommends HealthWave, the acceptanceHealthWave, the acceptance rate is muchHealthWave, the acceptance rate is n workwork with the agency to help them understand the work with the agency to help them und customers,customers, and remain available to assist with explanations,customers, and remain availabl specificspecific to the community.specific to the community. This also builds the relationshipspecific to the co and the specific minority community.

BeforeBefore representatives went to the NativeBefore representatives went to the Native American tribes, expectationexpectations,expectations, how texpectations, how they should dress and the decorum expe clcloseclose ticlose ties with the tribes had to do with a repetition of the message, being available for numerousnumerous events, and offering the Indian Henumerous events, and offering the Indian HealthWaveHealthWave benefits. Success was known when lettersHealthWave benefits. Success was kno childchild in child in specifichild in specific counties. Names and addresses were provided by the RepresentativesRepresentatives have been invited to powwows when no other vendor was allowed to attend

bebecausebecause the tribes have come to trust HealthWave and know that only representativebecause t
honor their customs will be sent.

TheThe rural communities in Kansas have very high enrollment rates baThe rural communities in K
populationpopulation estimates establishedpopulation estimates established when HealthWavepopulation es
thethe fact that an outreach worker is willing to comethe fact that an outreach worker is willing to come to
WithinWithin three months of theWithin three months of the program s start,Within three months of the pro
county,county, even though many of them are rural and the targeted number ofcounty, even though many of
ninenine and seventy per county. Outreach workers are stationednine and seventy per county. Outreach wo
hired from local communities which helps potential families believe in the program.

EffectivenessEffectiveness in reaching minority and immigrant populations isEffectiveness in reaching mino
events,events, revents, resevents, responses to quality checks, and the applications received from
applicationapplication assistanceapplication assistance event.application assistance event. The rural commu
tools of reviewing the applications and enrollments from each county every month.

C. Which methods best reached which populations? How have you measured effectiveness?

AllAll segments of the community resAll segments of the community responAll segments of the commu
WICWIC pick-up days. Representatives work to network with social WIC pick-up days. Represent
businesses,businesses, and vendors at any health fair, and they often bbusinesses, and vendors at a
invitations.invitations. This is true for ruralinvitations. This is true for rural areas as well as minorityinvitati
that outreach must become immersed in whatever community they are targeting.

RepresentativesRepresentatives spent a significant amount ofRepresentatives spent a significant amount of t
MostMost of the staff went to cultural competencyMost of the staff went to cultural competency training con
areas were the African Americanareas were the African American population,areas were the African Amer
thethe Lthe Latthe Latino population. One staff member completed national certification as a Spanis
interpreter.

TheThe best methods for outreach continueThe best methods for outreach continue to be the one-on-one co
readyready to discuss health insurance with an outreach coordinator who is well trainedready to discuss healt
knowledgeknowledge and how to work with each segment of their territory sknowledge and how to work
effortsefforts help make the communityefforts help make the community aware of the program andefforts he
to come and receive information and an application.

HealthWaveHealthWave measures the effectiveness of outreach through aHealthWave measures the ef
reports.reports. First, the number of applications receivedreports. First, the number of applications received
targets.targets. Secotargets. Second, the number of children and teens enrolled in each county f
HealthWaveHealthWave and Medicaid is compared toHealthWave and Medicaid is compared to theHealth
thethe number of tthe number of theithe number of their events and the total number of people who a
informationalinformational booth, meeting or coldinformational booth, meeting or cold calls ininformationa
to what they hear about HealthWave and how well it is being accepted in the community.

2.5 Retention:

A. WhatWhat steps is yourWhat steps is your State taking to ensure that eligibleWhat steps is your State takin SCHIP?

RecentRecent studies through the Kansas Health Institute indicate thatRecent studies through the Kansas H locationlocation is more successful at retaining enrollees. In July, Klocation is more successful at retaining en programsprograms in an effort to increase retention. We also bprograms in an effort to increase retention. We weeksweeks prior to their redetermination in order to increase theweeks prior to their redetermination in order to inc monitor retention and make adjustments where necessary.

B. What special measures are being taken to reenroll children inWhat special measures are being taken to reen still eligible?

____ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
__X__ Targeted mailing to selected populations, specify population _____
____ Information campaigns
____ Simplification of re-enrollment process, please describe _____
__X__ Surveys Surveys or Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, pl describe _____ Other, please explain_____

OurOur eligibility system automatically notifiesOur eligibility system automatically notifies families when th returningreturning a redetermination form. Thareturning a redetermination form. That is one oreturn familyfamily to send in the redetermination form. family to send in the redetermination form. Also, we have r itit is one page,it is one page, fit is one page, front and back. We hope this streamlining will increase t rerenewals.renewals. We implemented this in July, so it is still early to discern its effectiveness.renewal mentionedmentioned in A, postcards are sent to families two weeksmentioned in A, postcards are sent to fa form in the mail.

InIn addition, the Kansas Health Institute (KHI) continues to study retention fIn addition, the Kansas H Kansas.Kansas. They have previously studied childrenKansas. They have previously studied childre months. Nowmonths. Now they are focusing on those families who do notmonths. Now they are focusi KHIKHI is conducting focus groups andKHI is conducting focus groups and surveys with consumers and also ininin order to develop recommendations. The State of Kansas is anxiously awaiting their recommendations and will modify policy and procedures accordingly.

C. AreAre Are the Are the same measures being used in Medicaid as well? If not, please describe differences.

Yes.

D. WhichWhich measures have you found to be most effective at ensuring that eligible children stay enrolled?

KHIKHI KHI has been able to compare Title 21 and Title 19 populations and ascertain the averKHI has duration for enrollees. They have alsoduration for enrollees. They have also been able toduration for enr movingmoving from Title 21 to Title 19moving from Title 21 to Title 19 and vice versa, or if themoving fro insuranceinsurance altogether. The surveys and focus groups they are doing shoinsurance altoget informationinformation about why childreninformation about why children leave the public healthinformatio ofof immeasurable importance to the State ofof immeasurable importance to the State of Kansas. Simply hav beenbeen useful as we have been able to tell some been useful as we have been able to tell some of th identifiedidentified someidentified some of the preventable administrative actions that cause disenrollment relatedrelated to our automated eligibility system and have taken action torelated to our automated eligib thethe future. The additional analysis from KHI will enhance ourthe future. The additional analysis fro disenrolldisenroll from Title 21 and Title 19. They shoulddisenroll from Title 21 and Title 19. They shou summer.

E. WhatWhat do you know aWhat do you know aboutWhat do you know about insurance coverage of th SCHIPSCHIP (e.g., how many obtain other public or private coverage, how SCHIP (e.g., how uninsured?) Describe the data source and method used to derive this information.

BasedBased on information inthe IssueBased on information in the Issue Brief No.Based on information int one third of the children leaving HealthWave21one third of the children leaving HealthWave21 between Ja the program) and June 30, 2000, moved directlythe program) and June 30, 2000, moved directly into the M statusstatus of the remaining two thirds ofstatus of the remaining two thirds of the children was unknown. findings from KHI as part of their three-year study.

2.6 Coordination between SCHIP and Medicaid:

A. DoDo you useDo you use common applicationDo you use common application and redetermination proced and interview requirements) for Medicaid and SCHIP? Please explain.

Yes,Yes, we have the sameYes, we have the same procedures for redetermination thatYes, we have the sam thethe samethe same application form thatthe same application form that is designed for children/family medi forfor the specific information necessary to determine eligibility forfor the specific information necessary to d threethree months othree months of wathree months of wage and income verification. If we recei verification,verification, we will attempt toverification, we will attempt to do the redetermination with the i can t, we will attempt to call the family and get the information over the phone if possible.

B. ExplainExplain how childrenExplain how children are transferred betweenExplain how children are transfer status changes.

ChildrenChildren moving from SCHIP to Medicaid andChildren moving from SCHIP to Medicaid and vice useuse the same eligibility system to make the deteruse the same eligibility system to make the determ contractcontract staff socontract staff so State scontract staff so State staff can do the final Medicaid de

additionaladditional information from the family. Eligibiliadditional information from the family. Eli
programs, so for the most part,programs, so for the most part, the requirements for the family are the sam
healthhealth Managed Care Organization (MCO) is the same for both SCHIP and Medicahealth Manage
childchild may move from the MCO to a PCCM provider or vice versa if changing fuchild may move
streamsstreams,streams, but if he or she was assigned to the MCO in one program, she or he wilstrea
assignedassigned to the same MCO under the other program. The child will most likely be able to see
thethe same provider. The benefitthe same provider. The benefit packages forthe same provider. The bene
of Kansas.

C. AreAre the same deliveryAre the same delivery systems (includingAre the same delivery systems (including
Please explain.

TheThe same physical health delivery systemsThe same physical health delivery systems are used between
portionportion of Medicaid)portion of Medicaid) and HealthWaveportion of Medicaid) and HealthWave 21 (
areare similar, but are not identical. The delivery systems for dental and mare similar, but are not iden
operateoperate as coordinators of services, as adoperate as coordinators of services, as admoperate a
whereaswhereas these contractors providewhereas these contractors provide all services under a capitated
Title 21.

2.7 Cost Sharing:

A. HasHas your State undertaken any asHas your State undertaken any assessment oHas your State und
participation in SCHIP? If so, what have you found?

No. This has not been done.

B. HasHas your StateHas your State undertakenHas your State undertaken any assessment of the effects
health service under SCHIP? If so, what have you found?

No. This has not been done.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currentlyWhat information is currently available on the quality of care receivedWhat in
Please summarize results.

SincSinceSince qualitySince quality standards were not required in a stand-alone SCHIP program
regulationsregulations became final inregulations became final in August 2001, the qualityregulations beca
fully developed in the last year. However, the state s contractfully developed in the last year. However, t
forfor Medicalfor Medical Care,for Medical Care, the External Quality Review Organization used for Health
evaluations, was expandedevaluations, was expanded on October 1,evaluations, was expanded on October
SomeSome information was collected withSome information was collected with the CAHPS survey (summ

B. WhatWhat processes are you uWhat processes are you using to What processes are you using to mo
enrollees,enrollees, particularlyenrollees, particularly with respect toenrollees, particularly with respect to w
health, substance abuse counseling and treatment and dental and vision care?

TheThe StateThe State of Kansas isThe State of Kansas is collecting HEDIS measures on all of the progra
visionvision care. Encounter datavision care. Encounter data is used to report immunizations for use in qua
reimbursement of vaccine costs to the VFC program.

C. WhatWhat plans does your SCHIP program haveWhat plans does your SCHIP program have for future n
care received by SCHIP enrollees? When will data be available?

SeeSee the answer in A. See the answer in A. AsSee the answer in A. As part of the EQRO review, the phy
accessaccess to care will be evaccess to care will be evaluatedaccess to care will be evaluated, com
providerprovider surveys will beprovider surveys will be evaluated, and an immunization study willprovider su
are due at various times over the next fiscal year.

SECTION 3. SUCCESSES AND BARRIERS

ThisThis section has been designed to allow youThis section has been designed to allow you toThis section has andand implementation of your State plan, to identify barrierand implementation of your State plan, implementation, and to describe your approach to overcoming these barriers.

3.1 PleaPleasPleasePlease highlight successes and barriers you encountered during FFY 2001 in th followingfollowing areas. Please report the approaches used to overcome barriers. Befollowing areas. Plea specific as possible.

Note:Note: If there is nothing to highlight as a successNote: If there is nothing to highlight as a success orNote:

A. Eligibility

AA local challenge is our stateA local challenge is our state statute which prohibits use ofA local challenge forfor HealthWave 21, except for the most limitedfor HealthWave 21, except for the most limited mandatesmandates capitated managed care statewide. Duemandates capitated managed care statewide. Du toto offer up to three months prior coverage as is available in the Medto offer up to three months prior OctoberOctober 1, 2001, daily eligibility and assignment (i.October 1, 2001, daily eligibility and determination) was instituted. This policy willdetermination) was instituted. This policy will help childr quickly,quickly, and will eliminate part of the eligibility discrepancy between familiesquickly, and will elimin with eligibility in both Title 19 and Title 21 programs.

B. Outreach NA

C. Enrollment NA

D. Retention/disenrollment NA

E. Benefit structure NA

F. Cost-sharing NA

G. Delivery system

TheThe physical health contractor forThe physical health contractor for HealthWave 21 and capitatedThe p known as HealthWaveknown as HealthWave 19, is the same as of July 1, 2001.known as HealthWave 19 contractorcontractor for both programs will enhance continuity of care contractor for both programs streams. Distinct mental health and dentalstreams. Distinct mental health and dental services contractors ofof care for the Title 19 managed care population and are continuing the stateof care for the Title 19 required capitated care for the Title 21 population.

H. Coordination with other programs NA

I. Crowd-out

AsAs of JulyAs of July 1, 2001, the state statuteAs ofJuly 1, 2001, the state statute was amended to eliminat
familiesfamilies losing other insurance coverage. The state plan was afamilies losing other insurance c
change.

J. Other NA

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 PleasePlease complete Table 4.1 to provide your budgetPlease complete Table 4.1 to provide your budg budget,budget, and FFY 2002 projectedbudget, and FFY 2002 projected budget. budget, and FFY 200 planned use of funds.

Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01.

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care	31,769,105	45,050,000	56,750,000
per member/per month rate X # of member months	128.80 X 246,657	146.27 X 307,985	149.92 X 378,526
Fee for Service	266,303	350,000	450,000
Total Benefit Costs	32,035,408	45,400,000	57,200,000
(Offsetting beneficiary cost sharing payments)	477,674	540,000	690,000
Net Benefit Costs	31,557,734	44,860,000	56,510,000
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)	2,667,362	3,021,106	4,255,677
Claims Processing			
Outreach/marketing costs	1,620	1,295,174	1,681,493
Other			
Total Administration Costs	2,668,982	4,316,280	5,937,170
10% Administrative Cost Ceiling	3,506,415	4,984,444	6,278,889
Federal Share (multiplied by enhanced FMAP rate)	2,521,112	3,583,816	4,514,521
State Share	985,303	1,400,629	1,764,368
TOTAL PROGRAM COSTS	34,226,716	49,176,280	62,447,170

*Note:*Note: Prior to September 2001, outreach and marketing*Note: Prior to September 2001, outreach and mark reporting, it will be.

4.2 PleasePlease identify the total State expendituresPlease identify the total State expenditures for family 2001.

None, for Title 21 in FFY 2001.

4.3 WhatWhat were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions
__X__ Foundation grants (for outreach only)
_____ Private donations (such as United Way, sponsorship)
__X X__ Other (specify) Tobacco Settlement funds (.85% of total non-Federal funds) Tobacco Settler

A. DoDo you anticipate any changesDo you anticipate any changes in the sources Do you an expenditures?

No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

ThisThis section has been designed to give the reader of your annual report some This section has been desig glimpse of your SCHIP program.

5.1 ToTo provide a summary at-a-glance of your SCHIP program charTo provide a summary a provideprovide the following information. If you do not have a particular policy in-place. If you do not h like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	N/A	HealthWave 21
Provides presumptive eligibility for children	____No ____Yes, for whom and how long?	__X__ No ____Yes, for whom and how long?
Provides retroactive eligibility	____No ____Yes, for whom and how long?	__X__No (except in limited circumstances for infants) ____Yes, for whom and how long?
Makes eligibility determination	____State Medicaid eligibility staff ____Contractor ____Community-based organizations ____Insurance agents ____MCO staff ____Other *(specify)* _____	__X__State Medicaid eligibility staff __X__Contractor ____Community-based organizations ____Insurance agents ____MCO staff ____Other *(specify)* _____
Average length of stay on program	Specify months____	Specify months__12__
Has joint application for Medicaid and SCHIP	____No ____Yes	____No __X__Yes
Has a mail-in application	____No ____Yes	____No __X__Yes
Can apply for program over phone	____No ____Yes	__X__No ____Yes
Can apply for program over internet	____No ____Yes	__X__No ____Yes
Requires face-to-face interview during initial application	____No ____Yes	__X__No ____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	____No ____Yes, specify number of months _____ What exemptions do you provide?	__X__No (effective 07/01/01, prior to that time, a 6-month waiting period was required) ____Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage regardless of income changes	____No ____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	____No __X__Yes, specify number of months __12__ Explain circumstances when a child would lose eligibility during the time period: move from state, enter foster care or juvenile justice system, enter HCBS program, death
Imposes premiums or enrollment fees	____No ____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	____No __X__Yes, how much?* __$10 per family per month from 151%of FPL to 175% of FPL; $15 per family per month from 176% of FPL to 200% of FPL__ Who Can Pay? __X__ Employer __X__ Family __X__ Absent parent __X__ Private donations/ sponsorship ___ Other (specify) _____
Imposes copayments or	____No	__X__No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
coinsurance	_____Yes	_____Yes
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__X__ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

*Families*Families with incomes between 151% and 175% FPL pay a monthly premium of $10. For fa*Families with incomes
betweenbetween 176% and 200% FPL the monthlybetween 176% and 200% FPL the monthly premium is $15. These are perbetwe
onon theon the number of children covered. Upon enrollment, families are allowed to decideon the number of children covered. Upon
quarterly,quarterly, or annually. Families receive a monthly statement indicating the amount curquarterly, or annually. Fa
previouslypreviously paid and (if applicable) the pastpreviously paid and (if applicable) the past due amount. The statement comes wi
andand a postage-paid return envelope. If theyand a postage-paid return envelope. If they are behind onand a postage-paid return e
themthem to become current and advising them of the consequences of not being current at the timethem to become current and advi
areare not disenrolled for the family s failurare not disenrolled for the family s failureare not disenrolled for the family s f
However,However, all requiredHowever, all required premiums must be paid before a child will be allowed to reenroll for theHowev
assuming they are determined to be eligibleassuming they are determined to be eligible at renewal. assuming they are determined t
past due premiums are paid.

5.2 PleasePlease explain how Please explain how the redePlease explain how the redetermination process.

TheThe redetermination application formThe redetermination application form is a one-page form, with limited spe
redetermination form is sent 45 days prior to the renewal date.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 AsAs of September 30, 2001, what was the income standard or threshold,As of September 30, 2001, ofof the Federal poverty level, for countable income for each group?of the Federal poverty level, for byby the child s age (or date of birth), then report each threshold for eachby the child s age (or date of birth Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931 - whichever category is higher	150% of FPL for children under age 1 133% of FPL for children aged 1 through 5 100% of FPL for children aged 6 through 21
Medicaid SCHIP Expansion	NA % of FPL for children aged _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
SeparateSeparate SCHIP Program	200% of FPL for of FPL for children aged 00 through 18,0 through eligible for Medicaid ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 AsAs of September 30, 2001,As of September 30, 2001, what typAs of September 30, 2001, what typ program use to arrive at total countableprogram use to arrive at total countable income? *Please indicat or deduction used when determining eligibility foror deduction used when determining eligibility for ea NA.*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$200 per wage earner	$ NA	$200 per wage earner
Self-employment expenses	25% of gross income or actual income producing costs	$ NA	25% of gross income or actual income producing costs
Alimony payments Received	$0	$ NA	$0
Paid	$0	$ NA	$0
Child support payments Received	$0	$ NA	$0
Paid	$0	$ NA	$0
Child care expenses	$0 (included in wage earner deduction)	$ NA	$0 (included in wage earner deduction)
Medical care expenses	$0	$ NA	$0
Gifts	$0	$ NA	$0
Other types of disregards/deductions (specify)	None	$ NA	None

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

__X__No ___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program NA

____No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

__X__ No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____ NA

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001? ___ Yes

__X__ No

SECTION 7: FUTURE PROGRAM CHANGES

ThisThis section hasThis section has been designed to allow you to share recent or anticipatedThis section has program.

7.17.1 What changes have youWhat changes have you made or are planning to makeWhat changes have y FFYFFY 2002(FFY 2002(10/1/01 through 9/30/02)? PleaseFFY 2002(10/1/01through 9/30/02)? Pl

A. Family coverage NC

B. Employer-sponsored insurance buy-in NC

C. 1115 waiver NC

D. Eligibility including presumptive and continuous eligibility NC

E. Outreach

TheThe outreach function was shifted fromThe outreach function was shifted from the CThe outrea offices effective October 1, 2001.

F. Enrollment/redetermination process NC

G. Contracting - providers/enrollment broker

It is anticipated that a new enrollment broker/fiscal agent will begin providing servicesIt is anticipated th 1,1, 2002. This contractor wil1, 2002. This contractor will pr1, 2002. This contractor will provi Initially,Initially, the contractor willInitially, the contractor will maintain current systems forInitially, the an entirely new system by July 1, 2003.

H. Other NC